SELECTIVE USE OF MAGNETIC RESONANCE CHOLANGIO-PANCREATOGRAPHY (MRCP) PRIOR TO LAPAROSCOPIC CHOLECYSTECTOMY

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Introduction: The optimum strategy for investigating patients with symptomatic gallstones who have risk factors for common bile duct (CBD) stones is unclear. We have established an imaging protocol for patients at risk for CBD stones prior to laparoscopic cholecystectomy (LC).
Method: Patients with symptomatic gallstones have either i) deranged liver function tests (LFTs), ii) a history of jaundice or iii) pancreatitis, iv) dilated biliary system on ultrasound scan, undergo an MRCP one week prior to cholecystectomy. Patients who had an abnormal MRCP underwent Endoscopic Cholangio-Pancreatogram (ERCP) that week followed by surgery.
Results: A total of 43 patients from June 2005 to October 2006 underwent MRCP prior to LC. Seven patients (16%) were found to have CBD stones and subsequently underwent ERCP. MRCP demonstrated aberrant anatomy in 2 patients (5%). The median interval between MRCP and Cholecystectomy was 7 days (Range 0 to 95 days). There were no complications following ERCP. All patients in the series had cholecystectomy, 40 patients (93%) via a laparoscopic route.
Discussion: We have demonstrated that scheduling of MRCP, and ERCP if required, one week prior to LC is feasible. The short time interval between pre-operative cholangiography and surgery may reduce the incidence of retained CBD stones.

MANAGEMENT OF RECTAL CANCER IN A DISTRICT GENERAL HOSPITAL-A TEN YEAR EXPERIENCE

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In the U.K., colorectal cancer is the third most common cause of cancer related mortality. The Association of Coloproctology of Great Britain and Ireland (ACPGBI) published updated guidelines for management of colorectal cancer in 2007. Current practice suggests that rectal cancer is best managed in centralised units; the role of the District General Hospital is unclear at present.

Aims: To determine if outcomes for patients undergoing surgery for rectal cancer in Daisy Hill Hospital are consistent with ACPGBI guidelines.
Methods: Retrospective case note review, using standardised proforma for patients treated for rectal cancer at Daisy Hill from 1/1/99 - 31/12/08. Results ACPGBI guidelines in brackets 109 patients treated for rectal cancer in Daisy Hill Hospital over 10 year period. Abdomino-perineal resection rate 22% (<30%). Overall perioperative mortality 0% for electively resected cancers ,12.5% for palliative/emergency procedures (< 7% for elective, < 20% for emergency procedures). Anastomotic leak rate 4.1% (<8%). 93% of patients had total mesorectal excision (TME) for anterior resection. 5 year survival by Duke's stage: 83.3% Duke's A, 58.8% Duke's B, 28.5% Duke's C, 0% Duke's D. Overall 5 year survival 41% (49% - CRUK 2006). Local recurrence rate 1.8% (∼ 10%). Wound infection rate 6.5% (∼ 10%).

RE-ENTRY DEVICE (OUTBACK LTD) COULD MEAN THE END OF SURGERY FOR LONG ILIAC ARTERY OCCLUSIONS

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Aims: To determine the efficacy of subintimal angioplasty, aided by lumen re-entry device (Outback Ltd), as an alternative to surgery in long iliac artery occlusions.
Methods: This was a pilot study of subintimal angioplasty, with a re-entry device included 42 patients with median age of 60 years who had lifestyle limiting claudication (n = 20) or critical limb ischaemia (n = 22) were included. All iliac occlusions were type C (n = 25) and type D (n = 17) according to TASC classification. The primary outcome measure was patency at follow up. Secondary outcome measures were technical failure, late occlusions, complications, length of hospital stay and reduction in the use of surgical bypasses.
Results: The patency rate was 90% at a mean follow up of 14 months. There were 2 technical failures because of heavy calcification and 4 late occlusions when surgical bypass was later required. There were no complications and all patients were discharged within 24 hours. There was a downward trend in the use surgical bypasses for iliac occlusions during the study.
Conclusions: Subintimal angioplasty with a re-entry device is feasible for long iliac artery occlusions. It provides an excellent patency rate, one-day hospital stay and reduces in the need for surgical bypasses.

SERVICE IMPROVEMENT STRATEGY FOR THE INSERTION OF SUPRAPUBIC CATHETERS

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Aims: To provide service improvement to all patients requiring insertion of a suprapubic catheter (SPC) by introducing an outpatient service. This will: • Decrease Theatre/General anasethetic requirement and patient admission • Increase patient satisfaction and safety with SPC service • Provide an optimal training environment.
Methods: A comparison of patients undergoing first SPC insertion before and after instigation of the outpatient(OP) SPC clinic utilising the MediPlus Seldinger SPC system.
Results: A total of 99 SPCs were inserted July 2007 – July 2009, comparing SPC inserted via Trocar to the Seldinger SPC. We have dramatically reduced the GA administered for SPC insertion 90% vs 3% following introduciton of the SPC clinic with average length of stay being 28mins vs. 2.3 days when compared to Trocar SPC. 100% patients were highly/satisfied with procedure. We have increased theatre availability, 91% SPCs inserted in general/day surgery when using the Trocar compared with 11% on introduction of the clinic.
Conclusions: Introduction of the SPC outpatient clinic has increased patient satisfaction & safety. We have reduced the requirements for theatre/general anaesthetic with its associated morbidity and mortality and reduced length of stay, reducing cost to the NHS. Finally we have provided an optimal training environment for all doctors to acquire this skill.

MULTIPLE RENAL TUMOURS: ONE STEP BEYOND CONSERVATIVE MANAGEMENT

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Introduction: Cryoablation of small (<4cm) incidental renal tumours is well reported with excellent outcomes at short/intermediate follow-up (3 years). Its use in the management of multiple and bilateral renal

tumours is less well reported. We report our initial experience of managing multiple small renal tumours with cryotherapy in high risk patients with considerable co-morbidities.
Materials and methods: In 18 months, we treated 2 patients with multiple small renal tumours with laparoscopic cryoablation. They both had significant comorbidities (ASA3), but maintained an active quality of life. A transperitoneal approach was used in both. Four and three ipsilateral renal tumours ranging from 10mm to 30mm were treated with 5 and 4 cryotherapy needles (2.4mm) respectively. The treatment included double 10 minute freeze-thaw cycles. The treatment was carried out under vision and laparoscopic ultrasound guidance.
Results: The operation times were 170 and 300 minutes, with minimal blood loss and no complications. The hospital stay was 2 and 5 days. The estimated GFR did not change. There is no radiological evidence of recurrence in one patient at 20 months, the second patient approaches 6 months follow-up.
Conclusion: Cryotherapy is an alternative safe treatment option for multiple small renal tumours in high risk candidates.

PATIENT PERCEPTIONS OF URODYNAMIC INVESTIGATION

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Introduction: Patients are considerably anxious before urodynamic investigations (UDSI). Anecdotally, patients' perceptions of UDSI improve following the test. The aim of this study is to investigate patients' perceptions before and after UDSI.
Method: 80 consecutive patients recorded their pre-test anxiety level on a 10cm visual analogue scale (VAS) ranging from "not at all anxious" to "extremely anxious". Immediately after UDSI, all patients were asked to record on the VAS the level of anxiety they felt towards UDSI being repeated. A two-tailed t-test was performed to identify any difference between pre and post test VAS.
Results: 31 males and 49 females (25-82 years, mean 58.53 years) were included in the study. All had the procedure explained to them before completing the VAS. VAS reduced post-test in 58, increased in 8 and remained unchanged in 14 patients. The mean pre-test score (3.93) was significantly greater than the mean post-test score (1.69), (mean difference = 2.25, SD = 2.47); t stat = 8.14, $p<0.001$, suggesting that patients' perceptions regarding further UDSI testing is improved.
Conclusion: 72.5% of patients were less anxious about having a repeat UDSI. This information can be used in future to reassure patients.

A SINGLE–INSTITUTION EXPERIENCE IN USE OF BACILLE CALMETTE-GUERIN (BCG) IN SUPERFICIAL BLADDER CANCER

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Introduction: Intravesicle BCG decreases the risk of progression in bladder cancer. The aim of the study was to assess if maintenance BCG is reliably achieved beyond 12 months.
Methods: Between April 2005- August 2008, 54 patients were started on BCG maintenance therapy. We analyzed patient case notes, and assessed the duration of BCG treatment as our primary measure, and reasons for failure to complete maintenance and clinical outcome as secondary measure.
Results: Of the 54 patients identified, 16 (26.6%) had low risk, 10 (18.5%) intermediate risk and 28 (51.9%) had high-risk superficial bladder cancer. Only 12 (22.2%) completed the full course of maintenance treatments at 6 monthly intervals. 28 (51.9%) completed at least 12 months of maintenance therapy. Of 14 (25.9%)patients who failed to complete 12 months of BCG maintenance therapy, 7(50%)had disease progression, 5(35.7%) had BCG related side effects and 2(14.3%)died. Of 5 patients who stopped treatment due to side effects, 4 of then had progression of disease. Out of the 11 patients who had disease progression, 4(36.4%) underwent cystectomy.
Conclusion: Initial BCG therapy and cystectomy could the answer for high drop off rates and toxicity with use of maintenance BCG in High-grade superficial bladder cancers.

ROUTINE EARLY POST-OPERATIVE DUPLEX SCANNING IS UNNECESSARY FOLLOWING CAROTID ENDARTERECTOMY

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Introduction: The primary aim of the study was to determine whether routine early duplex scanning following carotid endarterectomy (CEA) is beneficial in identifying recurrent or residual disease and whether it has any role in preventing further neurological events.
Methods: A retrospective review of patient case-notes was performed on all patients undergoing CEA between January 2001 and March 2008. Patients had post-operative duplex scans within 3 months of surgery.
Results: There were 184 CEA operations performed during the assessed period. The mean patient age was 68 years (range 49-88 years). Male to female ratio was 127:57. Of these 127 were performed under general anaesthesia and 57 under local anaesthesia. Three patients (1.6%) died in the early post-operative period. Abnormalities were detected in 9 (10.3%) cases. Two had occlusions, 2 ulceration, 1 thrombus, 8 with residual stenosis of 50-60%, and 6 with a residual stenosis of 60-70%. None of the scanned patients had clinical symptoms related to the carotid territory on which had been operated.
Discussion: These results show that early post-CEA duplex scanning is of limited clinical value. However, this practice is reassuring for the patient and provides good documentary evidence of quality control and the technical abilities of surgical trainees.

BENCHMARK ASSESSMENT VERSUS LOCAL AUDIT FOR THE MANAGEMENT OF PATIENTS WITH POTENTIALLY CURATIVE OESOPHAGO-GASTRIC CANCER

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Aims: North of Scotland Cancer Network (NOSCAN) have used a benchmark assessment (BA) to report current practice and service quality for patients with oesophago-gastric (OG) cancer in the North of Scotland. The assessment was based on SIGN 87 (management of OG cancer, 2006). Our aim was to compare results of BA against a local audit for the management of patients with potentially curative OG cancer.
Methods: A retrospective audit was performed of patients referred with potentially curative OG cancer (March 2005 – March 2009). Data extracted included the 69 recommendations detailed in the NOSCAN assessment. The audit data was compared to the BA response.
Results: 75 consecutive patients underwent potentially curative resection (oesophageal [n = 25], junctional [n = 26] and gastric [n = 24]). The BA